Schneider
Medicaid

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

February 14, 2008

The Honorable Henry Waxman
Chairman, Committee on Oversight and Government Reform
House of Representatives
Congress of the United States
2157 Rayburn House Office Building
Washington, DC 20515-6143

RE: Your letter of January 16, 2008

Dear Chairman Waxman:

Enclosed please find our responses to the questions you sent us on January 16, 2008.

We believe that the budget reductions that would result from the implementation of these seven regulations would be massive and would severely impair the ability of states to maintain a health care system for their neediest citizens. We appreciate your attention to this important matter.

We would also like to mention one other proposed rule that was not mentioned in your letter. On December 28, 2007, the Department of Health and Human Services published a proposed rule regarding the Departmental Appeals Board, which would essentially allow CMS to overrule decisions made by the DAB. The promulgation of this rule undermines the critical role that the DAB has played in reviewing agency actions and removes an important check that is available when the agency takes actions against states that are not supported in the law. We would like to see this rule withdrawn.

Please contact us if we can provide additional information.

Sincerely,

Darin J. Gordon
Director, Bureau of TennCare

cc: Tennessee delegation

Analysis of Proposed Rules
Tennessee

1. **Cost limits for public providers (CMS 2258-C)**
Proposed by CMS on May 29, 2007.
Under Congressional moratorium, the effective date of the rules was delayed until May 25, 2008.
CMS cost savings estimate (across all states): $120 million in FY 08; $3.87 billion over 5 years.

   a. **Analysis for Tennessee.** This proposed rule would severely limit the revenue sources and costs that are available to a state in generating its share of Medicaid expenditures.

   First, the rule restricts the definition of public providers that can participate in Medicaid funding arrangements to those with "generally applicable taxing authority" or who are an "integral part of a unit of government with taxing authority which is legally obligated to fund the health care providers' expenses, liabilities, and deficits, so that a contractual arrangement with the state or local government is not the primary or sole basis for the health care provider to receive tax revenues."

   Under this definition, the only Tennessee hospital that would indisputably qualify for CPE is Metro General in Nashville. The other large charity hospitals have some administrative characteristic that would prevent them from qualifying or that would make it difficult for them to qualify. As an example, the Regional Medical Center at Memphis (known as The MED) is a huge safety net hospital that serves three states and provides more than $200 million in charity care annually. It is the oldest hospital in Tennessee; more than half of all physicians working in Tennessee have trained there. Its trauma center is one of the top five in the country in terms of numbers of patients treated. Yet The MED would not qualify as a "public provider" under these rules because it is set up as a 501(c)3 organization.

   It should be noted that the government of Shelby County, where The MED is located, contributes a large amount of funds to operate The MED for the benefit of all of its residents. Tennesseans are thus contributing a large amount of taxpayer funds toward this cause; it seems eminently reasonable that federal funds would be used to match the local expenditures per the original vision of a federal/state partnership.

   There are many hospitals in Tennessee that provide a large volume of both charity care and TennCare services and that should appropriately be considered "public providers." The fact that these hospitals may have been organized legally in ways that allow them to achieve gains in efficiency or to be more attractive to potential investors does not mean that their expenses should not be recognized as public expenditures for the purpose of obtaining Medicaid matching dollars.

Second, the rule limits allowable payments to the individual public provider's "cost of providing Medicaid services to eligible Medicaid recipients," which means that the payments would simply make up the difference between what a public provider had been paid by Medicaid and what its actual cost of delivering a particular service was. There is no recognition given to the costs incurred by the provider in delivering non-covered services or in serving other, non-Medicaid, persons whose ability to pay for care is extremely limited.

Third, only expenditures already made can be counted. Expenditures accounted for in a refund or reduction in accounts receivable would not be allowed. It appears that providers would have to make prospective revenue transfers prior to receiving actual payments for care.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** $200 million per year.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** Reductions of this size would obviously have a dramatic effect on Medicaid applicants and beneficiaries in Tennessee. Possible responses to these reductions include reducing program enrollment, reducing program benefits, and/or reducing provider payment rates.

2. **Payment for Graduate Medical Education (CMS 2279-P)**
Proposed by CMS on May 23, 2007.
Under Congressional moratorium, the effective date of the rules was delayed until May 25, 2008.
CMS cost savings estimate (across all states): $140 million in FY 08; $460 million over 5 years.

a. **Analysis for Tennessee.** This proposed rule eliminates the availability of federal support for Graduate Medical Education (GME) programs. This proposal will affect Tennessee differently from how it affects other states where GME funds are absorbed by various teaching hospitals. Tennessee has a unique GME program that is recognized under the TennCare demonstration and that has been used to develop primary care capacity in Tennessee. TennCare GME funds have been targeted to medical schools in Tennessee rather than to hospitals, as they are in most states. These funds allow these teaching universities to pay stipends for medical students who are getting their training in primary care and also helps support training in primary care settings other than hospitals. The residents provide health care in a wide variety of settings that serve rural areas and low income populations. The development of a workforce that is skilled in delivery of primary care services is essential to meeting the overall health goals of the TennCare program.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** $32 million per year.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** The effect of this reduction would mean that there would be fewer physicians trained in primary care and available to serve

Medicaid applicants and beneficiaries, as well as other low income persons. Many rural and low income areas of Tennessee would lose the services of residents who are now available to provide care.

3. **Payment for hospital outpatient services (CMS 2213-P)**
Proposed by CMS on September 28, 2007; no effective date as yet.
CMS cost savings estimate (across all states): No estimate provided because of "lack of available data."

a. **Analysis for Tennessee.** Tennessee does not pay for hospital outpatient services through its State plan. These services are paid for by Managed Care Organizations under contract with the state. Some of the concerns expressed by other states—namely, that some services classified as "outpatient services" could no longer be classified and paid for as "outpatient services"—are largely irrelevant in Tennessee, since the TennCare MCOs negotiate rates for all the services they cover and have no incentive to categorize services in one way or another in order to pay more than they would otherwise have to pay.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** None.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** None.

4. **Provider taxes (CMS 2275-P)**
Proposed by CMS on 3/23/07 with an effective date of 1/1/08.
CMS cost savings estimate (across all states): $85 million in FY 08; $115 million in FYs 09-11.
Note: PL 109-432 (Tax Relief and Health Care Act) required that the maximum amount that a state could receive from a health care-related tax is 6 percent. This amount was temporarily reduced to 5.5 percent between January 1, 2008, and September 20, 2011.

a. **Analysis for Tennessee.** This tax would affect a gross receipts tax currently in effect for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). This tax is currently required by Tennessee Code Annotated 68-11-830(d) and is established at 6% of the gross receipts of ICFs/MR operating in the state.

Tennessee also has a general nursing home provider tax. This tax, which is required by state law [TCA 68-11-216(c)], is currently $2,225 per licensed bed per year. The tax is not limited to nursing homes that participate in Medicaid.

Tennessee is concerned that the amendments move away from the clear cut rules that enable a state to determine whether it is or is not in compliance to a more subjective test that is purposefully ambiguous.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** $1.5 million per year.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** The reductions in revenue that could occur as the result of this proposed rule would have a negative impact on Medicaid applicants and beneficiaries in Tennessee, in that revenue streams that have been in place for years cannot easily be replaced. In the final analysis, reductions in program revenues could mean a reduction in provider payments, a reduction in the benefits offered by the program, or a reduction in the number of people who can be served.

5. **Coverage of rehabilitative services (CMS 2275-P)**

Proposed by CMS on 8/13/07; under Congressional moratorium, effective date was delayed until 6/30/88.

CMS cost savings estimate (across all states): $180 million in FY 08; $2.2 billion over 5 years.

Note: There is a new definition of "rehabilitation" that is included in the manager's amendment to the Indian Health Care Improvement Act Amendments of 2007 (HR 1328). The new definition broadens the definition of "rehabilitation" at 42 CFR 440.140(d).

a. **Analysis for Tennessee.** One problem with analyzing rules such as this is that the scope of the replacement rule can quickly outgrow the scope of the original rule. In our view, there is only one service offered under TennCare that qualifies as "rehabilitative," and that is mental health rehabilitation services. The Department of Mental Health and Developmental Disabilities in Tennessee has said that the requirements outlined in this rule are largely already being followed in mental health rehabilitation services.

There is a second service which is an issue in Tennessee, however. For many years, Tennessee has offered "children's therapeutic intervention services" to DCS custody children through the state's Title V agreement, which is an agreement that complies with 42 CFR 431.615. "Children's therapeutic intervention services" are therapeutic services provided to children in DCS placements; these services represent the portion of the child's residential day that is devoted to treatment.

Recently, CMS staff located on-site at the Bureau of TennCare have opined that these services should be considered "rehabilitative services," which would make them fall under the scope of this proposed rule. Some of the provisions of the rule that would impact the current arrangement are as follows:

- Therapeutic foster care cannot be paid for with a single daily rate, case rate, or similar rate to the provider; each service must be billed separately, requiring detailed accounting by all providers.
- Therapeutic foster care parents must be defined as providers under the State plan.
- Activities that are determined to be the responsibility of the foster care system would not be covered.
- Covered rehab services cannot be "intrinsic elements" of other programs, such as foster care, child welfare, education, juvenile justice, etc.

- If the DCS custody child has mental retardation, "habilitation" services cannot be covered under the "rehab" option.

The case management rule discussed separately in this document will already decimate the foster care system in Tennessee. Defining the remaining services that TennCare covers for the foster care population outside of the managed care organizations will finish it off.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** The possible effect is unclear, but if CMS defines DCS services as "rehabilitation services," then there could be an impact of $50 to $60 million per year.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** The case management rule discussed separately in this document will have a profound effect on the foster care system in Tennessee. Defining the remaining services that TennCare covers for the foster care population outside of the managed care organizations will finish it off. With such a dramatic reduction in funding, the state will likely be unable to meet its obligations under the *Brian A.* lawsuit, which could result in the taking over of the Tennessee foster care system by the court.

6. **Payments for costs of school administrative and transportation services (CMS 2287-P)**
Final rule on 12/28/07; delayed effective date of 6/30/88..
CMS cost savings estimate (across all states): $635 million in FY 09; $3.6 billion over 5 years.

a. **Analysis for Tennessee.** TennCare does not currently claim funding for administrative services performed by school employees or contractors or for routine transportation from home to school and back for school-age children with an IEP or IFSP.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** None.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** None.

7. **Targeted case management (CMS 2237-IFC)**
Proposed by CMS on 12/4/07 with an effective date of 3/3/08.
CMS cost savings estimate (across all states): $1.28 billion between FY 08 and FY 12.

a. **Analysis for Tennessee.** The regulation is entitled "targeted case management," which one would think applies to a specific Medicaid service called "targeted case management." However, CMS makes it clear that they interpret "targeted case management" to encompass all kinds of case management activities, including administrative case management and even case management delivered

in Home and Community Based Services (HCBS) waivers. This interpretation is at variance with all of the previously published guidelines about case management, including the State Medicaid Manual.

Tennessee has one TCM program that is operated under the State plan, and that is TCM for children in state custody or at risk of state custody. About 10,000 persons are served in this program at any given time. Persons providing the TCM services are state employees working for the Department of Children's Services. Only the portion of their time that is devoted to assisting children in getting and keeping medical appointments, following up on medical referrals, etc., is counted as "targeted case management" for Medicaid reimbursement purposes; the Medicaid program is not charged for case management activities having to do with court appearances, making placement arrangements, etc. However, CMS apparently presumes that *no* case management services provided by state workers for custody children should be reimbursable under Medicaid, and has included that prohibition in this rule.

Tennessee also covers "mental health case management" under our 1115 TennCare demonstration. This service, which was covered under the State plan as TCM prior to the implementation of TennCare, addresses coordination of care for persons whose functioning is impaired because of mental illness. About 60,000 persons per year are served in this program.

Tennessee has five 1915(c) Home and Community Based Services (HCBS) waiver programs, all of which include case management as a service. Three of these programs are for persons with mental retardation, and two are for persons who are elderly and/or disabled. About 7,300 people are served in these programs.

Tennessee has several administrative case management arrangements, including an arrangement with the Department of Human Services to provide case management for adults who are unable to protect themselves due to a physical or mental limitation and who have been identified as abused, neglected, or financially exploited. About 6,000 persons are served in this program.

We do not believe that CMS's interpretation of Congressional intent regarding targeted case management, as included in the DRA, is correct. However, assuming that the interpretation is correct, there is no way that the state can dismantle the current system and build a new one in time to be in compliance with this "interim final rule" on March 3, 2008.

b. **Estimate of the expected reduction in federal Medicaid funds to Tennessee over each of the next five years.** $70 million per year.

c. **Estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Tennessee.** The recipients of case management services in Tennessee are, by and large, among the most vulnerable persons in our program—children in state custody, persons who are mentally ill, persons with mental retardation, persons who are aged and/or disabled enough to require nursing facility care, and adults who require protective services to prevent abuse, neglect, or financial exploitation. It is unfair to make these persons bear the

brunt of CMS's "sledgehammer" approach to cutting costs, as exemplified in this rule.